FOR THOSE WHO MUST SHARE THE BURDEN OF VIETNAM: A GUIDE TO SUPPORT GROUP FORMATION

An Honors Thesis (HONRS 499)

by

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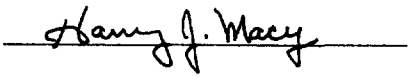

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ABSTRACT

Emphasizing a recognized need for knowledge and understanding of the Vietnam experience and the effects of Post-Traumatic Stress Disorder upon the veteran and significant others, this thesis proposes a guide to aid in the formation and implementation of a self-help group for partners of those afflicted with the syndrome by addressing the symptoms of the disorder; its effects on the veteran and his family system; group formation and facilitation; and, includes a personal diary suggestive of 'snags', faux pas, and false starts.

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Nancy Mason
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INTRODUCTION

Although more than two decades have elapsed since the direct involvement of the United States in the Vietnam Conflict, the label of post-traumatic stress disorders as a diagnostic tool is of more recent origins. For a number of years following disengagement, the national mental health and health care communities were seemingly unaware of the 'residual effects of the Vietnam War on the veteran'.[1] Although Patti Coleen Brown has confirmed that not all Vietnam veterans will be found to have become 'seriously troubled' by the experience--successful integration within the civilian community being influenced by such variables as the number of tours of duty in Southeast Asia, combat exposure, and individual pre-service and post-service histories--she has cautioned the social work professional concerning the importance of knowledge of military history as a source of insight into the family system and its dysfunction.[2]

Although the process of reentry from "the Nam" to "the World" must remain central to the veteran, the experience of problems during decompression--a sensation found to be similar to reentry from outer space--may render the family's needs for support and information acute,[3] and while the concept of the self-help group for 'partners' of Vietnam veterans is neither new nor unique, the attributes of this medium are widely acknowledged and accepted, and the

techniques have proven successful in promoting individual change and self-improvement through consciousness raising, improved social functioning, or increased conformity to social norms.[4]

Embracing clinical summaries of the dysfunction and historical perspectives, the guide that follows was developed during the course of formation of a self-help group for partners* in conjunction with The Vietnam Veterans Family Assistance Program, and addresses the factors involved in group formation, the conduct of the initial and subsequent meetings, and group termination. This thesis, which incorporates a diary of personal experiences acquired during group creation and facilitation, is published in recognition of a continuing need to provide personal assistance to those indirectly affected by PTSD--those who must share the burden that was Vietnam.

* As used in this work, the term 'partner' is limited to women in relationships with male veterans.

I.

POST-TRAUMATIC STRESS DISORDER DEFINED

Post-traumatic Stress Disorder (PTSD), an anxiety disorder characterized by the manifestation of defined symptoms following an extremely distressing event that is "outside the range of usual human experience", was formally recognized by the American Psychiatric Association in 1981 by its inclusion in the Diagnostic and Statistical Manual of Mental Disorders.[5] The symptoms of this disorder, to include a subtype known as Delayed Stress Response Syndrome (distinguished by a delay of six months or more in the onset of symptoms), have been found to affect Vietnam veterans experiencing combat, and have been defined by S.M. Silver and C.U. Iacono,[6] as follows:

1. DEPRESSION, manifested by poor concentration, low self-esteem, failing interest in job or activities, memory loss and suicidal tendencies.

2. RESIDUAL GRIEF, also known as survival guilt, reflecting itself in feelings of guilt or sorrow about behavior in Vietnam or surviving the loss of comrades in combat.

3. REEXPERIENCE OF TRAUMA, resulting in nightmares, violent dreams or fantasies, flashbacks of Vietnam, or the reliance upon combat responses in non-military settings and situations.

4. DETACHMENT AND ANGER, evidenced by irritability, loss of temper, hyperalertness, and anxiety; feelings of emotional distance from families and others, or of separation from country or society; and, fear of loss of self-control.

II.

THE AFFECTS OF PTSD ON THE VETERAN AND HIS PARTNER

Although PTSD is a disorder with characteristics common

to the symptomatic definitions, influences such as family status, personal traits, education, and combat experience are suggestive of variations in the effects of the following manifestations upon the veteran and his partner:[7]

EMOTIONAL NUMBING: Veterans exposed to combat situations of great danger have been found to respond by masking their emotions through an encompassing focus of attention upon surviving. However, the reliance upon this ability or technique to address problems or difficulties encountered upon return to the civilian community often results in misunderstanding and the creation of emotional distance in relationships.[8]

Marriages and other familial relationships requiring the sharing and expression of intimate feelings will be found to suffer from the veteran's fear of loss or emotional pain and the resultant inability to form or maintain close, personal relationships.[9] Furthermore, this inability to communicate emotionally, which is often found to alternate with periods of perceived normalcy, may engender anger in the veteran's partner, and foster feelings of worthlessness, helplessness, withdrawal, and depression within the relationship.[10]

SEXUAL ISSUES: As with the more general concept of numbing, the symptoms of PTSD may adversely affect the veteran's sexual response which will, in turn, negatively impact the sexual relationship with his partner. Thus, the veteran, fearing the physical and emotional vulnerability that comes

with having intimate sexual relations, may abstain, or if seeking relief from personal anxiety and depression, may become overdemanding and fail to recognize the needs and desires of his partner. In either event, the lack of mutuality in the sexual relationship can only result in a failure of intimacy and emotional bonding which will suggest a primary weakness in the partnership.[11]

ISOLATION: As suggested by Tom and Candis Williams, the Vietnam veteran, having once found himself to be a member of a group which considered itself to be isolated, unique, and misunderstood, may seek reinforcement of these feelings upon his return to the civilian community. Through isolation and association with veterans with similar combat experiences, he is able to avoid feelings of personal confusion, ambiguity and self-blame concerning his wartime activities; is able to attribute his current problems and troubles to an external source such as Agent Orange or, more generally, the government; and, is likely to suffer from lapses in personal control and accountability for his actions outside the group.[12]

Although isolation may occur through physical separation from family and society, it often results from adherence to the unspoken rule that combat experiences will not be related outside of the group and with those who did not share the burden. While, perhaps, avoiding distress to family members by refusing such a recount, the resulting repression

adversely affects the ability of the veteran to relate and integrate his wartime behavior with his peacetime identity; perpetuates his perception of himself as different or special; and, promotes emotional isolation from significant others. The veteran who becomes jealous of a partner who enjoys social activities outside of the unit may require the severance of such ties, thereby denying his partner needed social support, creating an unhealthy co-dependent relationship, and reinforcing his own isolation and that of his immediate family.[13]

SUBSTANCE ABUSE: The abuse of alcohol or drugs as a method of coping with the atrocities of war became the acknowledged, if not accepted, way of life for many Vietnam servicemen, and as the result of addiction or the need to suppress emerging symptoms of PTSD, substance abuse returned with the veteran to the civilian community. Although partners of Vietnam veterans may be unable to determine the specific cause of this substance abuse, they quickly learn that the financial stability of the family and the relationships between its members might well suffer as a result. In her attempts to address this problem, the partner may first serve as an "enabler" through efforts to cover or excuse the veteran's behavior, but, when finally forced to "confront" the problem, she may find that the recognition by others of this abuse will result in alienation from friends, family members, and community.[14]

PHYSICAL ABUSE: The physical abuse of a veteran's partner has been recognized as a companion of substance abuse, and has been found, according to a Vet Center study, to affect 25 percent of all pairings.[15] This abuse tends to occur when the veteran experiences a flashback to the war, during outbursts of rage or extreme anger, and as the result of feelings of helplessness over some aspect of his civilian life.[16] While the act of battering may enable the veteran to recapture the sense of strength and masculinity experienced during combat, and his conditioning to violence permit him to trivialize the injuries inflicted, this violence may not be attributable to PTSD alone--substance abuse may be a contributing, if not the dominant factor.[17]

ANGER AND RAGE: Although outbursts of anger and rage may result in physical abuse, a veteran afflicted with PTSD may attempt to direct these feelings inward and suppress them. As witnessed by his partner, expressions of anger and verbal abuse are often seen as being inappropriate and misdirected, and a realization that this anger may reflect unresolved feelings of the veteran concerning his experiences in Vietnam may be slow in arising. In her attempts to cope, the partner may respond with anger of her own, or her attempts to suppress these feelings may mirror those of the veteran. The resulting resentment, depression and anxiety within the relationship, and the lack of a viable outlet for these emotions, may cause the media portrayal of the Vietnam

veteran as an angry and violent individual to be self-fulfilling.[18]

FAMILY DYSFUNCTION: The partner of a veteran suffering from symptoms of PTSD may find herself promoted to the position of sole or primary provider of emotional and financial comfort within the family unit. As the assumption of this role will, of necessity, reduce the functioning level of the veteran as traditional "head of household", and as the elevation may be accompanied by feelings of guilt or fault for his problematic behavior, she may be faced with a conflict between the level of support and toleration necessitated by her partner's deviant behavior and the nature and extent of the personal sacrifices required of her position. If she conforms to the cultural expectation of total responsibility for the veteran's welfare and well-being, she will find herself perpetuating the cycle in which the partner is seen as the responsible party in the relationship, the veteran the irresponsible one--a reinforcement of the way they may both view their relationship. If, on the other hand, she attempts to strike and maintain a balance between personal and spousal needs, she must be prepared to assume and address the anxiety and conflict that will necessarily follow.[19]

The difficulties experienced by the veteran and his partner in relating to one another are suggestive of those found in the parent-child relationships within the unit. Although a spousal relationship devoid of intimacy due to

isolation, depression, or numbing might well characterize the parent-child bond of the veteran, his partner may use this same relationship to compensate for such deficiency.[20] While the veteran may be overly protective and demanding of his children as the result of ambivalence arising from combat experiences, his partner may seek to buffer this relationship, be unappreciated and misunderstood by both, and exacerbate the estrangement and emotional distancing between parent and child. When the veteran fails to provide emotional and physical nurturing, his children feel unwanted, unloved and inadequate, but consistent with cultural expectations, his partner may receive their criticism and blame.[21]

Perhaps, children are but "partners" of the Vietnam veteran. They may experience his mixed emotions, feelings and loyalties as they pertain to the family unit; they may feel 'different' because of substance abuse or the other symptoms of his PTSD; they may recognize the alienation that impinges upon his relationships with others--they must share the guilt, rage, and remorse that was Vietnam.

As the combat experiences of the individual veteran remain an important factor in ascertaining variances in the effects of the disorder upon his partner and family, a review of certain historical aspects of the Vietnam Conflict may add perspective to an otherwise clinical analysis of the disorder and be found of value in self-help group formation

and facilitation.

III.

POST-TRAUMATIC STRESS SYNDROME: HISTORICAL DIMENSIONS

As American involvement in the Vietnam conflict escalated, military planners, according to Jim Goodwin,[22] began a study of previous war experiences with a view toward the development of a plan to alleviate psychological disorders in combat situations. During the 'police action' in Korea, a system had been implemented which provided for the serviceman's eligibility for return to the United States after accumulation of an established number of points. This system was prompted by a recognition that the duration of the combat experience had a direct relationship with the incidence of disability due to psychological causes.[23] Expanding upon the apparent benefits of this system of limited and defined periods of combat duty, DEROS was implemented during the war in Vietnam.

With his tour being fixed at twelve or thirteen months, depending upon the branch of service, every enlisted individual knew his Date of Expected Return from Overseas, and although this plan adopted the underlying premise of the 'point system', certain disadvantages eventually became evident. As few large 'units' were sent to the war zone after the first years of the conflict, under DEROS, tours of duty became solitary, individual episodes which, when coupled with the nature and characteristics of guerrilla warfare,

contributed to the onset of emotional distress. Combatants constructed fantasies of homecoming based upon their date of rotation and the belief that they would return home unaffected by the experience and be welcomed by an unchanged society, and the short-timers calendar became a symbol of both anticipation and guilt.[24]

Although the training regimen of the individual services relied upon the 'unit' concept and the formation of social bonds, the replacement system, for the most part, funnelled individuals rather than units into the conflict. For the combatant, the closeness with and reliance upon others engendered during 'basic' was supplanted by the needs of the individual and a fear of replacements who lacked experience and those skills believed necessary for survival; and as the individual soldier turned inward for his own survival, he sought adjustment to the stresses of combat through the abuse of alcohol or drugs or through antisocial behavior.[25]

The guerrilla type of warfare which characterized the Vietnam War was outside the range of usual human experience. Its unpredictable nature constantly challenged ideologies of right and wrong, and military strategies were often confusing and conflicting. The inability to observe or measure the progress of the conflict or the success of individual operations, a mistrust of our Vietnamese allies, and the death and destruction inflicted by and upon the combatants contributed to feelings of outrage and grief and the physical

and emotional fatigue of the participants.[26] Even as rotation to the States remained a continuing goal of all who served, the end of the tour was often plagued by the onset of 'short-timer syndrome', mixed feeling of joy and guilt about departure from the combat zone--joy in the leaving but guilt for abandoning those who must then face the dangers and atrocities alone.[27]

The pattern of neuropsychiatric disorders for combatants in Vietnam has proved different than the experience of World War II and Korea. Although the incidence of such disorders during previous conflicts had increased directly with the intensity and duration of combat, such was not the case during the Vietnam era. Instead, these disorders began to increase only when the war was winding down and reached their peak at the end of direct American troop involvement in 1973.[28] Perhaps the pattern of neuropsychiatric disease during the Vietnam War may be found to be a reflection upon the attributes and limitations of the DEROS system and a monitor of the changing attitudes of Americans toward involvement in the conflict. As the war drew to a close, the solitary warrior, having fought his personal battles, was welcomed home, not to the strains of martial music, but to the drumbeat of political division, changing values, and hostility for those who had served.

Although Post-Traumatic Stress Disorder, as it affects the Vietnam veteran, remains an individual dysfunction

tracing its roots to the DEROS system, the nature of the guerrilla combat experience, and the changing political and social climate which characterized the Vietnam era, its affects upon the partner, children and family of the afflicted veteran are bound by a common thread--the requirement that these significant others must experience the manifestations of the veteran's syndrome. It is this 'common thread' that suggests the viability of the self-help group approach--understanding through communication.

IV.

FORMATION OF THE SELF-HELP GROUP

According to Alfred H. Katz and E. Bender, self-help groups are formed by those who have come together for assistance in satisfying common needs, overcoming common handicaps, or encouraging personal change, while features of such groups include face-to-face interaction, personal participation, and spontaneous relations among its members.[29] Although the results of group participation may be therapeutic, self-help groups are to be distinguished from therapy groups which involve specific treatment by professionals.[30]

The self-help group is characterized by the sharing of knowledge and experiences so as to provide its individual members with new options for addressing common problems, and although the specific focus of the groups may differ, the underlying premise of providing emotional support remains

constant.[31] The group model used by the Vietnam Veterans Family Assistance Program (Family Assistance Group) in developing a program for partners of Vietnam veterans is patterned after that outlined by Linda Donnan and Sue Lenton in Helping Ourselves,[32] as well as that implemented by the Disabled American Veterans Outreach Program (DAV Group)[33] specifically for 'partners', and focuses upon support through interaction; education concerning the effects of PTSD on the family system; and, information pertaining to community resources available to satisfy the needs of the members and their families.

The authors of Helping Ourselves have suggested the importance of membership, size and format as factors in the formation and later facilitation of the self-help group:

MEMBERSHIP: Similarity of personal traits such as age, sex, and educational achievements will assist in creating homogeneity within the group.

GROUP SIZE: With a group focus including the sharing of experiences, the optimal size would include from five to twelve members. If fewer, the members may have difficulty maintaining high energy levels; if more, certain members may be left out or overlooked.

FORMAT: Although the open format may provide a source of fresh ideas and insights through new membership, the closed group will foster a closeness and trust among its members, openness within discussions, and will avoid conflict

resulting from varying levels of development and achievement of the individuals.[34]

In addition, the following considerations have been suggested as being important to group formation and success:

DURATION: The DAV Group was time-limited, but with an option to recontract for additional sessions. Experience suggested that the avoidance of a format of indefinite duration encouraged membership, provided or suggested structure, and eliminated stagnation which might result from the exhaustion of topics or issues for discussion or the attainment of goals.[35]

LOCATION: Practical considerations suggest a location that is central to the group served, easy to locate, accessible, and includes convenient parking facilities and the availability of public transportation will encourage membership and participation. The avoidance of the facilitator's residence will help to insure that the location is perceived by the members as an attribute of the group and is "neutral".[36]

Consistent with the stated focus, and following a review and consideration of the formation factors as outlined, the Family Assistance Group was created utilizing a closed format with membership limited to partners currently maintaining a relationship with a veteran displaying PTSD symptoms. Although it was recognized that an expanded membership, to include partners of veterans not suffering from PTSD or of

those not presently experiencing symptoms, might broaden the experience base of the group and encourage understanding of and support for those presently 'sharing the burden', considerations of group size and homogeneity suggested this limitation.

Although matters of mechanics and considerations of size, format and location retain importance, flexibility is the byword as the group gathers and its members dictate parameters and direction.

V.

PHASE I: GETTING ACQUAINTED

Before the first meeting of the group, the organizer should establish and clarify the role of the facilitator--that individual who will assist in structuring the group, focusing its attention, and encouraging participation of the members. To avoid overreliance by the group upon the facilitator for direction and purpose, co-facilitation will help to insure differing perspectives from the 'leadership' while helping to reinforce the established role--to make the process easy.[37]

INTRODUCTIONS: At the first meeting, the facilitator should attempt to place each member at ease and attempt to create a feeling of comfort between and among them. The passing of name tags, offering of refreshments, and individual introductions may prove helpful in this regard.[38]

STATEMENT OF PURPOSES: As this meeting progresses and

becomes more formalized, the facilitator should restate the purposes of the encounter, emphasize the importance of individual participation, and solicit from the members those topics of discussion which each feels will lead to the fulfillment of the goals for which the group was formed.[39]

HOUSEKEEPING: The first meeting should also be used to assure, through agreement, the confidentiality of the proceedings if the group so intends; to establish a procedure for departing the group so as to minimize disruptions in continuity, the loss of group energy, and to permit closure through expressions of appreciation and personal exchanges; and to adopt an informal format for subsequent meetings. The first and all subsequent meetings should close on a positive note. Allowing each member to express thoughts concerning the accomplishments of the group and expectations for future gatherings has proven beneficial in this regard.[40]

VII.

PHASE II: DEFINING COMMON GOALS

COMMUNICATING: As group sessions continue and as members develop positive communication skills, a further identification of group concerns will occur, and it remains the task of the facilitator to insure that the direction and structure first formulated remain sufficiently flexible to assure goal attainment--education and support through sharing.[41]

MAINTAINING INTEREST: To assure continued interest and to

avoid stagnation, guest speakers might be sought to provide variety, address technical or complicated issues of group concern, and to augment educational efforts. Such presentations have been found most helpful when group members have been able to relate the matters discussed with group inquiries and their personal experiences.[42]

In this regard, the DAV Group began with an educational presentation relating to PTSD, after which members discussed problems of their partners. This exchange was supplanted by one concerning the effects of PTSD upon the family unit, and finally to one centered upon such effects upon the relationship of veteran and partner. At this juncture in group proceedings, as the members begin to acknowledge themselves and their own problems and needs, it becomes important for the facilitator to assure that participants become aware of existing programs and community resources available for assistance in problem solving, and to encourage the continuation of the process of resolution within the group and among members between sessions.[43]

VIII.

PHASE III: TERMINATION

Although before the last scheduled meeting, the topic of group discussion will most likely turn to concerns of dissolution, the relationships of trust and sharing between members created through the group process, if properly nurtured, will help to assure fulfillment of the group goals

of support and education through a continuing dialogue that postdates termination. Thus, the methodology of facilitation should include a continued restatement and reinforcement of group goals; encouragement of individual participation in the exchange of ideas; emphasis upon the development of communication and listening skills; and, focus upon the necessity of creating and maintaining 'comfort' among the members--while de-emphasizing his leadership role, the facilitator must, nevertheless, continually exercise his leadership skills to prepare the partners to positively direct the feelings of sadness and loss that will accompany group termination.

IX
THE FAMILY ASSISTANCE GROUP: A DIARY OF EVENTS

Although the importance of flexibility in group formation and conduct has been stressed, this 'byword' was not coined as a result of a perusal of the literature. Rather, personal experiences and insights acquired during the 'process' are suggestive in this regard . . .

THE FIRST DAY: My arrival at the Employment Training Office in downtown Muncie, to begin a four month tour of duty as a Student Advocate with the Vietnam Veterans Family Assistance Program (Family Assistance Program), was the culmination of my course of study in the Social Work Program at Ball State University and a month-long process of decision making regarding the mandatory practicum. Although excited about

the prospect of witnessing the practical application of the knowledge and skills acquired from the formal curriculum, I remained, nevertheless, anxious--I felt inadequate in dealing with a subject of which I had no direct knowledge, that, historically, had occurred before my birth, and, which involved individuals divorced by age and experience. In this regard, my meeting, that first day, with Janine Compton, my predecessor, was most opportune.

The Family Assistance Program, funded by the Agent Orange Class Assistance Program, became operational on January 1, 1991, with a focus on the assessment of needs of Vietnam veterans (including those not directly affected by chemical exposure) and their families, and fulfillment of those needs through a coordination of existing community resources. As Janine related, representative programs included support groups for veterans, direct counseling, procurement of inpatient therapy and medical services, and employment training--programs which were augmented by direct assistance in such matters as benefit eligibility and qualification, service linkage, outreach, and advocacy. I was relieved to learn that the concentration of my efforts would, at least initially, be limited to these 'secondary' subjects. That first day, I was shown to my office--a desk and chair shielded from the hustle and bustle of the hallway by two partitions, assigned ten files for analysis and review, and abandoned to suffer my uncertainties in solitude.

As my individual case study progressed, I was, perhaps, dismayed to learn that, if these clients were representative, most veterans sought financial aid or 'secondary' assistance, that the Student Advocate was the 'primary' provider of Program services, and that certain resources were utilized infrequently, if at all. As my association with the Family Assistance Program continued over the next weeks, this trend remained constant, except that I found that, more often, I was dealing not with the veteran but with his 'partner'.

My continuing concern with respect to the apparent perception of the program and under-utilization of services prompted discussions of these matters with Janine and Jerry Kerney, a post-graduate student intern who shares my duties and responsibilities. The resulting consensus suggested that not only were veterans failing to avail themselves of the full benefits to be derived from more active participation in the program, but that the largest beneficiary group, in fact, consisted of partners for whom no specific educational outreach existed--perhaps the program lacked a necessary mechanism to assure, through communication, its efficacy. It was upon this consensus that the Family Assistance Group was premised.

THE GROUP: Although Janine and I had agreed to collaborate on the formation of a self-help group for partners of Vietnam veterans, it was evident that the effectiveness of this relationship would require a broader knowledge of the Vietnam war, its aftermath, and its participants. Building upon the

personal experience and insights gained as a Student Advocate, a reading program was outlined and specific research on the subject of Post-Traumatic Stress Disorder was commenced, as several partners had expressed an interest in this disorder and had suggested the need for a self-help group with this focus. Included within this regimen was a review of source material on the subjects of group formation and facilitation.

Desiring to learn more, first hand, and with the advice and assistance of Don Burgess, Assistant Coordinator of the Family Assistance Program, arrangements were made to meet with an inpatient therapy group composed of Vietnam veterans suffering from PTSD, and conducted under the auspices of the Combat Veterans Treatment Program, Marion, Indiana. The discussions that ensued proved to be frank and open and confirmed the conclusions of writers on the subject--family dysfunction, being, in part, a product of the manifestations of the disorder, was aggravated by the symptomatic inability to communicate effectively with partners and significant others, and the lack of knowledge and understanding which necessarily results. The suggestion of a self-help group for partners of affected individuals was well received; endorsed by the group members and staff; and, appeared to confirm the need as expressed by the Muncie partners.

Having sought and confirmed the apparent need for a vehicle to encourage communication about the Vietnam

experience and the effect of PTSD upon the veteran and his family, and permit the dissemination of information pertaining to specific programs designed and implemented to address problems resulting from dysfunction, the outline for group formation, as set forth herein, was formulated. As related, the format chosen included five to twelve members in a closed group of limited duration. Unfortunately, this stylized, albeit accepted, formulation failed to illuminate the specific problems that were to surface.

THE FIRST MEETING: In selecting candidates for group membership, approximately 100 Family Assistance Program case files were reviewed to isolate those pertaining to veterans affected by PTSD. Of this sub-group, veterans without partners were eliminated as were those not presently manifesting symptoms of the disorder. Through this process, 16 potential members were identified, with four being eliminated because of travel distance to the proposed site, The North Anderson Church of God, Anderson, Indiana. On March 22, 1993, written invitations were prepared and mailed describing the purposes of formation, the location with directions, the time and date--April 5th at 7:00 PM; in anticipation of the first gathering, each potential member was personally contacted by phone (eight confirmed), the site reservation was fixed, and the 'ice breakers' prepared--cookies and chips and tea and coffee and name tags and information packets and . . . no one came!

THE SECOND MEETING: The 'ice breakers' could be preserved; but the question remained for Janine and I as to whether or not the same fate could be assured for the group. Although Jerry related, belatedly, that this result might have been expected, and that a common, and accepted, response would be to shift the burden of group formation to the potential members, we were not totally convinced of the effectiveness of this course. However, letters were written to each partner relating the experience of the first 'meeting' and requesting expressions of continuing interest by phone. Only one response was received--Sue responded affirmatively.

Feeling revived, if not rejuvenated, by this singular expression of need, I resolved to veer from the accepted and break new ground through a more social approach to personal relations--I initiated the calls, with the following results:

> Sue: related a fear of asking her fiancee to watch the children; complained of his objection to her formation of relationships outside the family; and suggested the unstableness of the relationship 'over the weekend'.
>
> Joan: attendance at the first meeting was precluded because of car trouble; the second letter was opened by her partner who expressed his disdain for the idea of self-help groups for partners and the ability of others to understand the Vietnam experience.
>
> Carol: although she expressed interest in the group concept and a desire to share her experiences and those of others, she was presently under the care of a therapist for anxiety and depression and was advised that the group approach to problem resolution was not appropriate at this time.
>
> Lisa: several attempts to make contact with this individual were unsuccessful; in several conversations with her partner it was intimated that she was 'not

interested' in participating and was preoccupied with the hospitalization of her daughter.

Helen: expressed concern that her experience with 'panic attacks' would not permit her participation without the attendance of someone trusted, and that she was hesitant to request that her partner attend with her. Helen also suggested reluctance to 'open up' for fear of not being able to 'close'.

Amy: experienced in psychiatric nursing and private counseling, indicated that she had been on vacation at the time of the first meeting, planned to attend subsequent meetings, and offered the opinion that the failure of others to attend might result from 'placing others before themselves'.

Patty: had a conflict with choir practice but remained interested in attending future meetings and discussing her son who had recently been released from Boy's School.

Kathy: attempts at personal contact were unsuccessful, and messages left with family members were not returned.

As the responses obtained were, primarily, related to the dysfunction anticipated to exist within the family, and with the confirmation of my faculty advisor, Dr. Harry Macy, Director, Department of Social Work, Ball State University, that three constitutes a workable group, the 'ice breakers' were unloaded at the church--which was found to be locked and bolted. Faced with the dilemma of locating a similarly 'neutral site,' the Waffle House in Anderson, Indiana, was selected as being handy and relatively quiet. The second meeting of the group, actually the first, was opened by Janine who dutifully passed the packets--the coffee and tea and chips and cookies seemingly out of place . . . .

CONCLUSION

While the Vietnam Memorial may list the names of those who fought and lost their lives in conflict, it fails, perhaps, as a statement of the personal suffering which continues to characterize the Vietnam War. Not listed are those who sought sanctuary in foreign lands and sacrificed freedom for an ideal; those who, once, sought to promulgate the myth of American Supremacy and efficacy of the Domino Theory; those who served with valor but failed to make the ultimate sacrifice; and, those who, by virtue of personal relationships, have assumed, in part, the burden that was Vietnam.

While the diary of events remains uncompleted, this omission is intended to serve as a reminder of the fact that new beginnings must be made and that the end of the Vietnam era is not yet in sight, for notwithstanding the passage of some 20 years, the present focus of Americana upon the exploits of Madonna, Mia and Woody and the seeming finality of the Memorial, Post-Traumatic Stress Disorder continues as a factor affecting the daily lives of partners residing in Muncie, Indiana, and that closure can only be found through communication.

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[14] Matsakis, p. 119-120.

[15] Ibid., p. 146.

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[36] Mallory, p. 36.

[37] Donnan and Lenton, p. 40-42.

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